Today's Date

_____/_____/_____

ARCHPOINT
Implant Dentistry

Office Use Only

Chart # _____-____

Scanned by _____

New Patient paperwork

Dr. James Hadley Hall DDS
Dr. Thomas Draper DMD, MD
Dr. Michael Oppedisano DMD, MS
Dr. Michelle Newby DDS, MS

Please circle how you heard about us?

TV	Internet	Newspaper	Radio	Doctor	Friend	NFED	Walk-In

Date of Birth _____ **Age** _____

Legal Name _____ Gender **Male** **Female**

Address _____

City _____ State _____ Zip Code _____

Cell _____ Home _____ Work _____

E-Mail _____ **Married** **Single** **Divorced** **Widowed**

Occupation _____ Employer _____

Preferred method of Contact **Phone Call** **Text** **Email**

Health History

1. Do you have any Major Medical Problems? **Yes** **No** Please explain: _____

_____

2. Are you a smoker? **Yes** **No** If so how much do you smoke daily? _____

3. Physicians Name _____ Phone Number _____

4. Is there any chance you could be pregnant? **Yes** **No** If so how many weeks _____

5. Have you been treated for any Periodontal Gum Disease? **Yes** **No** If yes, when _____

6. Do you have a family Dentist? **Yes** **No** Name _____ Last Visit _____

7. What is your main dental concern today? _____

8. Are you currently taking, or have you ever taken, any Bisphosphonates or any other medication for osteoporosis? **Yes** **No** Please list current or past prescribed Bisphosphonate drug(s)-for example: Actonel, Bonivia, Fosamax _____

9. My medical care and additional information regarding appointment, treatment , health care financing, referral information and test results may be discussed with the person listed below.

Name _____ Number _____ Relationship _____

10. Who is accompanying you today? _____ Relationship_____

11. Which is your chief concern regarding your teeth today.

Single Tooth **Multiple Teeth** **Top Teeth** **Bottom Teeth** **All of the Teeth**

12. Do any of your teeth hurt? **Yes** **No**

13. On a Scale of **1 (lowest urgency**) to **5** (**highest urgency**) where do you rate your current dental condition?

5 **4** **3** **2** **1**

14. When was your last teeth cleaning? **Within a Year** **Within 5 Years** **Within 10 Years**

15. Is todays visit a second opinion? **Yes** **No**

16. Do you wear removable partials? **Yes** **No**

17. Do you wear removable dentures? **Yes** **No**

18. Which is your personal dental priority? **Beautiful Smile** **Restore Function**

19.How often do you think about your dental condition? **Sometimes** **Most of The Time** **Constantly**

20. How long have you been thinking about doing a dental procedure? **Days** **Months** **Years**

21. How soon are you looking to schedule treatment? **Today** **30 days** **60 days** **90 days**

22. Rate your previous dental visit experiences. **Great** **Fair** **Poor** **Very Bad**

23. Which opportunities do you feel your dental situation causes you to miss out on?

Health/Diet **Dating** **Social Gatherings** **Speaking** **Singing** **Career** **Physical Activities**

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FREE 3-D CT SCAN

Your ArchPoint Dentist will interpret the 3-D CT Scan solely for the purpose of evaluating your upper and lower jaw for treatment planning and placement of your dental implants.

It has not been read for the presence of any medical condition. You may want to have this film interpreted by a Physician (Radiologist) of your choosing and at your expense for the presence of any possible medical condition(s).

I have read and elected to take the **FREE 3-D CT Scan**

Patient Signature: _____ Date: _____

Print Name: _____

****

Only sign if you would like a COPY of your 3-D CT Scan, ArchPoint will provide you with
one for a fee. We can refer you to a Maxillofacial Radiologist should you need a referral.

I have elected to take a Copy of the 3-D CT Scan for a fee of **$300.00**.

Patient Signature: _____ Date: _____